I

108TH CONGRESS
1ST SESSION

H. R. 2342

To amend title XVIII of the Social Security Act to expand Medicare benefits to prevent, delay, and minimize the progression of chronic conditions, and develop national policies on effective chronic condition care, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 4, 2003

Mr. STARK (for himself, Mr. RANGEL, Mr. MATSUI, Mr. MCDERMOTT, Mr. SANDLIN, and Mrs. JONES of Ohio) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to expand Medicare benefits to prevent, delay, and minimize the progression of chronic conditions, and develop national policies on effective chronic condition care, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Chronic Care Improvement Act of 2003''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—BENEFITS TO PREVENT, DELAY, AND MINIMIZE THE PROGRESSION OF CHRONIC CONDITIONS

Subtitle A—Improving Access to Preventive Services

SEC. 101. ELIMINATION OF DEDUCTIBLES AND COINSURANCE FOR EXISTING PREVENTIVE HEALTH BENEFITS.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by inserting after subsection (o) the following new subsection:

''(p) DEDUCTIBLES AND COINSURANCE WAIVED FOR PREVENTIVE HEALTH ITEMS AND SERVICES.—The Secretary shall not require the payment of any deductible or coinsurance under subsection (a) or (b), respectively, of any individual enrolled for coverage under this part for any of the following preventive health items and services:

''(1) Blood-testing strips, lancets, and blood glucose monitors for individuals with diabetes described in section 1861(n).

''(2) Diabetes outpatient self-management training services (as defined in section 1861(qq)(1)).

''(3) Pneumococcal, influenza, and hepatitis B vaccines and administration described in section 1861(s)(10).

''(4) Screening mammography (as defined in section 1861(jj)).

''(5) Screening pap smear and screening pelvic exam (as defined in paragraphs (1) and (2) of section 1861(nn), respectively).

''(6) Bone mass measurement (as defined in section 1861(rr)(1)).

''(7) Prostate cancer screening test (as defined in section 1861(oo)(1)).

''(8) Colorectal cancer screening test (as defined in section 1861(pp)(1)).

''(9) Screening for glaucoma (as defined in section 1861(uu)).

''(10) Medical nutrition therapy services (as defined in section 1861(vv)(1)).''.

(b) WAIVER OF COINSURANCE.—

(1) IN GENERAL.—Section 1833(a)(1)(B) of the Social Security Act (42 U.S.C. 1395l(a)(1)(B)) is amended to read as follows: ''(B) with respect to preventive health items and services described in subsection (p), the amounts paid shall be 100 per-

cent of the fee schedule or other basis of payment under this title for the particular item or service,''.

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after ''1861(s)(10)(A)'' the following: '', preventive health items and services described in section 1833(p),''.

(c) WAIVER OF APPLICATION OF DEDUCTIBLE.—Section 1833(b)(1) of the Social Security Act (42 U.S.C. 1395l(b)(1)) is amended to read as follows: ''(1) such deductible shall not apply with respect to preventive health items and services described in subsection (p),''.

(d) ADDING ''LANCET'' TO DEFINITION OF DME.—Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)) is amended by striking ''blood-testing strips and blood glucose monitors'' and inserting ''blood-testing strips, lancets, and blood glucose monitors''.

(e) CONFORMING AMENDMENTS.—

(1) ELIMINATION OF COINSURANCE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—Paragraphs (1)(D)(i) and (2)(D)(i) of section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) are each

amended by inserting ''or which are described in subsection (p)'' after ''assignment-related basis''.

(2) ELIMINATION OF COINSURANCE FOR CERTAIN DME.—Section 1834(a)(1)(A) of the Social Security Act (42 U.S.C. 1395m(a)(1)(A)) is amended by inserting ''(or 100 percent, in the case of such an item described in section 1833(p))'' after ''80 percent''.

(3) ELIMINATION OF DEDUCTIBLES AND COINSURANCE FOR COLORECTAL CANCER SCREENING TESTS.—Section 1834(d) of the Social Security Act (42 U.S.C. 1395m(d)) is amended—

(A) in paragraph (2)(C)—

(i) by striking ''(C) FACILITY PAYMENT LIMIT.—'' and all that follows through ''Notwithstanding subsections'' and inserting the following:

''(C) FACILITY PAYMENT LIMIT.—Notwithstanding subsections'';

(ii) by striking ''(I) in accordance'' and inserting the following:

''(i) in accordance'';

(iii) by striking ''(II) are performed'' and all that follows through ''payment under'' and inserting the following:

''(ii) are performed in an ambulatory surgical center or hospital outpatient department,

payment under''; and

(iv) by striking clause (ii); and

(B) in paragraph (3)(C)—

(i) by striking ''(C) FACILITY PAYMENT LIMIT.—'' and all that follows through ''Notwithstanding subsections'' and inserting the following:

''(C) FACILITY PAYMENT LIMIT.—Notwithstanding subsections''; and

(ii) by striking clause (ii).

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004.

SEC. 102. INSTITUTE OF MEDICINE MEDICARE PREVENTION BENEFIT STUDY AND REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall contract with the Institute of Medicine of the National Academy of Sciences to—

(A) conduct a comprehensive study of current literature and best practices in the field of health promotion and disease prevention among

medicare beneficiaries, including the issues described in paragraph (2); and

(B) submit the report described in subsection (b).

(2) ISSUES STUDIED.—The study required under paragraph (1) shall include an assessment of—

(A) whether each health promotion and disease prevention benefit covered under the medicare program is medically effective (as defined in subsection (d)(3));

(B) utilization by medicare beneficiaries of such benefits (including any barriers to or incentives to increase utilization);

(C) quality of life issues associated with such benefits; and

(D) whether health promotion and disease prevention benefits that are not covered under the medicare program that would affect all medicare beneficiaries are likely to be medically effective (as so defined).

(b) REPORTS.—

(1) THREE-YEAR REPORT.—On the date that is 3 years after the date of enactment of this Act, and each successive 3-year anniversary thereafter, the

Institute of Medicine of the National Academy of Sciences shall submit to the President a report that contains—

(A) a detailed statement of the findings and conclusions of the study conducted under subsection (a); and

(B) the recommendations for legislation described in paragraph (3).

(2) INTERIM REPORT BASED ON NEW GUIDELINES.—If the United States Preventive Services Task Force or the Task Force on Community Preventive Services establishes new guidelines regarding preventive health benefits for medicare beneficiaries more than 1 year prior to the date that a report described in paragraph (1) is due to be submitted to the President, then not later than 6 months after the date such new guidelines are established, the Institute of Medicine of the National Academy of Sciences shall submit to the President a report that contains a detailed description of such new guidelines. Such report may also contain recommendations for legislation described in paragraph (3).

(3) RECOMMENDATIONS FOR LEGISLATION.—The Institute of Medicine of the National Academy of Sciences, in consultation with the United States

Preventive Services Task Force and the Task Force on Community Preventive Services, shall develop recommendations in legislative form that—

(A) prioritize the preventive health benefits under the medicare program; and

(B) modify such benefits, including adding new benefits under such program, based on the study conducted under subsection (a).

(c) TRANSMISSION TO CONGRESS.—

(1) IN GENERAL.—Subject to paragraph (2), on the day that is 6 months after the date on which the report described in paragraph (1) of subsection (b) (or paragraph (2) of such subsection if the report contains recommendations in legislative form described in subsection (b)(3)) is submitted to the President, the President shall transmit the report and recommendations to Congress.

(2) REGULATORY ACTION BY THE SECRETARY OF HEALTH AND HUMAN SERVICES.—If the Secretary of Health and Human Services has exercised the authority under section 103(a) to adopt by regulation one or more of the recommendations under subsection (b)(3), the President shall only submit to Congress those recommendations under subsection (b)(3) that have not been adopted by the Secretary.

(3) DELIVERY.—Copies of the report and recommendations in legislative form required to be transmitted to Congress under paragraph (1) shall be delivered—

(A) to both Houses of Congress on the same day;

(B) to the Clerk of the House of Representatives if the House is not in session; and

(C) to the Secretary of the Senate if the Senate is not in session.

(d) DEFINITION OF MEDICALLY EFFECTIVE.—In this section, the term ''medically effective'' means, with respect to a benefit or technique, that the benefit or technique has been—

(1) subject to peer review;

(2) described in scientific journals; and

(3) determined to achieve an intended goal under normal programmatic conditions.

SEC. 103. AUTHORITY TO ADMINISTRATIVELY PROVIDE FOR COVERAGE OF ADDITIONAL PREVENTIVE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services may by regulation adopt any or all of the legislative recommendations developed by the Institute of Medicine of the National Academy of Sciences, in con-

sultation with the United States Preventive Services Task Force and the Task Force on Community Preventive Services in a report under section 102(b)(3) (relating to prioritizing and modifying preventive health benefits under the medicare program and the addition of new preventive benefits), consistent with subsection (b).

(b) ELIMINATION OF COST-SHARING.—With respect to items and services furnished under the medicare program that the Secretary has incorporated by regulation under subsection (a), the provisions of section 1833(p) of the Social Security Act (relating to elimination of cost-sharing for preventive benefits), as added by section 101(a), shall apply to those items and services in the same manner as such section applies to the items and services described in paragraphs (1) through (10) of such section.

SEC. 104. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL EXAMINATION.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(W) an initial preventive physical examination (as defined in subsection (ww));''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Initial Preventive Physical Examination

''(ww) The term 'initial preventive physical examination' means physicians' services consisting of a physical examination with the goal of health promotion and disease detection and includes a history and physical exam, a health risk appraisal, and health risk counseling, and laboratory tests or other items and services as determined by the Secretary in consultation with the United States Preventive Services Task Force.''.

(c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

(1) DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) is amended—

(A) by striking ''and'' before ''(6)'', and

(B) by inserting before the period at the end the following: '', and (7) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1861(ww))''.

(2) COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) in clause (N), by inserting ''(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))'' after ''80 percent''; and

(B) in clause (O), by inserting ''(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))'' after ''80 percent''.

(d) PAYMENT AS PHYSICIANS' SERVICES.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(W),'' after ''(2)(S),''.

(e) OTHER CONFORMING AMENDMENTS.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) by striking ''and'' at the end of subparagraph (H);

(B) by striking the semicolon at the end of subparagraph (I) and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(J) in the case of an initial preventive physical examination (as defined in section 1861(ww)), which is performed not later than 6 months after the date

the individual's first coverage period begins under part B;''; and

(2) in paragraph (7), by striking ''or (H)'' and inserting ''(H), or (J)''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004, but only for individuals whose coverage period begins on or after such date.

Subtitle B—Medicare Coverage for Care Coordination and Assessment Services

SEC. 111. CARE COORDINATION AND ASSESSMENT SERVICES.

(a) SERVICES AUTHORIZED.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''CARE COORDINATION AND ASSESSMENT SERVICES

''SEC. 1897. (a) PURPOSE.—

''(1) IN GENERAL.—The purpose of this section is to provide the appropriate level and mix of follow-up care to an individual with a chronic condition who qualifies as an eligible beneficiary (as defined in paragraph (2)).

''(2) ELIGIBLE BENEFICIARY DEFINED.—In this section, the term 'eligible beneficiary' means a beneficiary who—

"(A) has a serious and disabling chronic condition (as defined in subsection(f)(1)); or

"(B) has four or more chronic conditions (as defined in subsection (f)(4)).

"(b) ELECTION OF CARE COORDINATION AND ASSESSMENT SERVICES.—

"(1) IN GENERAL.—On or after January 1, 2005, an eligible beneficiary may elect to receive care coordination services in accordance with the provisions of this section under which, in appropriate circumstances, the eligible beneficiary has health care services covered under this title managed and coordinated by a care coordinator who is qualified under subsection (e) to furnish care coordination services under this section.

"(2) REVOCATION OF ELECTION.—An eligible beneficiary who has made an election under paragraph (1) may revoke that election at any time.

"(c) OUTREACH.—The Secretary shall provide for the wide dissemination of information to beneficiaries and providers of services, physicians, practitioners, and suppliers with respect to the availability of and requirements for care coordination services under this section.

''(d) CARE COORDINATION AND ASSESSMENT SERVICES DESCRIBED.—Care coordination services under this section shall include the following:

''(1) BASIC CARE COORDINATION AND ASSESSMENT SERVICES.—Except as otherwise provided in this section, eligible beneficiaries who have made an election under this section shall receive the following services:

''(A)(i) An initial assessment of an individual's medical condition, functional and cognitive capacity, and environmental and psychosocial needs.

''(ii) Annual assessments after the initial assessment performed under clause (i), unless the physician or care coordinator of the individual determines that additional assessments are required due to sentinel health events or changes in the health status of the individual that may require changes in the plan of care developed for the individual.

''(B) The development of an initial plan of care, and subsequent appropriate revisions to that plan of care.

''(C) The management of, and referral for, medical and other health services, including

multidisciplinary care conferences and coordination with other providers.

''(D) The monitoring and management of medications.

''(E) Patient education and counseling services.

''(F) Family caregiver education and counseling services.

''(G) Self-management services, including health education and risk appraisal to identify behavioral risk factors through self-assessment.

''(H) Consultations by telephone with physicians and other appropriate health care professionals, including 24-hour access to a care coordinator.

''(I) Coordination with the principal caregiver in the home.

''(J) The managing and facilitating of transitions among health care professionals and across settings of care, including the following:

''(i) The pursuit the treatment option elected by the individual.

''(ii) The inclusion of any advance directive executed by the individual in the medical file of the individual.

"(K) Activities that facilitate continuity of care and patient adherence to plans of care.

"(L) Information about, and referral to, community-based services, including patient and family caregiver education and counseling about such services, and facilitating access to such services when elected.

"(M) Information about, and referral to, hospice services and palliative care, including patient and family caregiver education and counseling about hospice services and palliative care, and facilitating transition to hospice when elected.

"(N) Such other medical and health care services for which payment would not otherwise be made under this title as the Secretary determines to be appropriate for effective care coordination, including the additional items and services as described in paragraph (2).

"(2) ADDITIONAL BENEFITS.—The Secretary may specify additional benefits for which payment would not otherwise be made under this title that may be available to eligible beneficiaries who have made an election under this section (subject to an assessment by the care coordinator of an individual

beneficiary's circumstances and need for such benefits) in order to encourage the receipt of, or to improve the effectiveness of, care coordination services.

''(e) CARE COORDINATORS.—

''(1) REQUIREMENT FOR CERTIFICATION.—

''(A) IN GENERAL.—In order to be qualified to furnish care coordination and assessment services under this section, an individual or entity shall be a health care professional or entity (which may include physicians, physician group practices, or other health care professionals or entities the Secretary may find appropriate) who has been certified for a period (as provided in subparagraph (B)) by the Secretary, or by an organization recognized by the Secretary, as having met such criteria as the Secretary may establish for the furnishing of care coordination under this section (which may include experience in the provision of care coordination or primary care physician's services).

''(B) PERIOD OF CERTIFICATION.—The period of certification for an individual referred to in subparagraph (A) is as follows:

"(i) A one-year period for each of the first three years of participation under this section.

"(ii) A three-year period thereafter.

"(2) ADDITIONAL REQUIREMENTS.—

"(A) SUBMISSION OF DATA.—A care coordinator shall comply with such data collection and reporting requirements as the Secretary determines necessary to assess the effect of care coordination on health outcomes.

"(B) PARTICIPATION IN QUALITY IMPROVEMENT PROGRAM.—A care coordinator shall participate in the quality improvement program under paragraph (3).

"(C) ADDITIONAL TERMS.—A care coordinator shall comply with such other terms and conditions as the Secretary may specify.

"(3) QUALITY IMPROVEMENT PROGRAM.—

"(A) IN GENERAL.—The Secretary shall establish a chronic care quality assurance program to monitor and improve clinical outcomes for beneficiaries with chronic conditions.

"(B) ELEMENTS OF PROGRAM.—Under the program, the Secretary shall—

"(i) establish standards to measure—

''(I) quality and performance of the care of chronic conditions;

''(II) the continuity and coordination of care that eligible beneficiaries under this section receive; and

''(III) both underutilization and overutilization of services;

''(ii) provide to care coordinators periodic reports on their performance on such measures; and

''(iii) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of care coordination options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate).

''(C) REVIEW OF CLAIMS.—

''(i) IN GENERAL.—Subject to clause (ii), under the program the Secretary shall make available to care coordinators claims data relating to a beneficiary for whom the coordinator coordinates care under this section for the coordinator's review and subsequent appropriate follow-up action.

"(ii) AUTHORIZATION.—Data may only be provided to a care coordinator under clause (i) if the eligible beneficiary involved has given written authorization for such information to be so provided.

"(4) LIMITATION ON NUMBER OF CARE COORDINATORS.—Payment may only be made under this section for care coordination services furnished during a period to one care coordinator with respect to an eligible beneficiary.

"(5) PAYMENT FOR SERVICES.—

"(A) IN GENERAL.—The Secretary shall establish payment terms and conditions and payment rates for basic care coordination and assessment services described in subsection (d).

"(B) PAYMENT METHODOLOGY.—Payment under this section shall be made in a manner that bundles payment for all care coordination and assessment services furnished during a period, as specified by the Secretary.

"(C) CODES.—The Secretary may establish new billing codes to carry out the provisions of this paragraph.

"(f) DEFINITIONS.—In this section:

''(1) SERIOUS AND DISABLING CHRONIC CONDITION.—The term 'serious and disabling chronic condition' means, with respect to an individual, that the individual has at least one chronic condition and a licensed health care practitioner has certified within the preceding 12-month period that—

''(A) the individual has a level of disability such that the individual is unable to perform (without substantial assistance from another individual) for a period of at least 90 days due to a loss of functional capacity—

''(i) at least 2 activities of daily living; or

''(ii) such number of instrumental activities of daily living that is equivalent (as determined by the Secretary) to the level of disability described in clause (i);

''(B) the individual has a level of disability equivalent (as determined by the Secretary) to the level of disability described in subparagraph (A); or

''(C) the individual requires substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

''(2) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' means each of the following:

''(A) Eating.

''(B) Toileting.

''(C) Transferring.

''(D) Bathing.

''(E) Dressing.

''(F) Continence.

''(3) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term 'instrumental activities of daily living' means each of the following:

''(A) Medication management.

''(B) Meal preparation.

''(C) Shopping.

''(D) Housekeeping.

''(E) Laundry.

''(F) Money management.

''(G) Telephone use.

''(H) Transportation use.

''(4) CHRONIC CONDITION.—The term 'chronic condition' means an illness, functional limitation, or cognitive impairment that—

''(A) lasts, or is expected to last, at least one year;

''(B) limits what a person can do; and

''(C) requires on-going medical care.

''(5) BENEFICIARY.—The term 'beneficiary' means an individual entitled to benefits under part A and enrolled under part B, including an individual enrolled under the Medicare+Choice program under part C.''.

(b) COVERAGE OF CARE COORDINATION AND ASSESSMENT SERVICES AS A PART B MEDICAL SERVICE.—

(1) IN GENERAL.—Section 1861(s) of the Social Security Act (42 U.S.C. 1395x(s)) is amended—

(A) in the second sentence, by redesignating paragraphs (16) and (17) as clauses (i) and (ii); and

(B) in the first sentence—

(i) by striking ''and'' at the end of paragraph (14);

(ii) by striking the period at the end of paragraph (15) and inserting ''; and''; and

(iii) by adding after paragraph (15) the following new paragraph:

''(16) care coordination and assessment services furnished by a care coordinator in accordance with section 1897.''.

(2) CONFORMING AMENDMENTS.—Sections 1864(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of such Act (42 U.S.C. 1395aa(a), 1396a(a)(9)(C), and 1396n(a)(1)(B)(ii)(I)) are each amended by striking ''paragraphs (16) and (17)'' each place it appears and inserting ''clauses (i) and (ii) of the second sentence''.

(3) PART B COINSURANCE AND DEDUCTIBLE NOT APPLICABLE TO CARE COORDINATION AND ASSESSMENT SERVICES.—

(A) COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(i) by striking ''and'' at the end of subparagraph (T); and

(ii) by inserting before the final semicolon '', and (V) with respect to care coordination and assessment services described in section 1861(s)(16) that are furnished by, or coordinated through, a care coordinator, the amounts paid shall be 100 percent of the payment amount established under section 1897''.

(B) DEDUCTIBLE.—Section 1833(b) of such Act (42 U.S.C. 1395l(b)) is amended—

(i) by striking ''and'' at the end of paragraph (5); and

(ii) by inserting before the final period '', and (7) such deductible shall not apply with respect to care coordination and assessment services (as described in section 1861(s)(16))''.

(C) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of such Act (42 U.S.C. 1395cc(a)(2)(A)), as amended by section 101(b)(2), is further amended by inserting after ''section 1833(p),'' the following: ''with respect to care coordination and assessment services (as described in section 1861(s)(16)),''.

SEC. 112. CARE COORDINATION AND ASSESSMENT SERVICES AND QUALITY IMPROVEMENT PROGRAM IN MEDICARE+CHOICE PLANS.

Section 1852(e)(1) of the Social Security Act (42 U.S.C. 1395w–22(e)(1)) is amended by inserting before the period at the end the following: '', including a quality improvement program for coordinated care services referred to in section 1897(e)(3)''.

SEC. 113. IMPROVING CHRONIC CARE COORDINATION THROUGH INFORMATION TECHNOLOGY.

(a) TECHNOLOGY IMPROVEMENT GRANTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (hereinafter in this section referred to as the ''Secretary'') shall make grants to eligible entities to enable such entities to develop, implement, or train personnel in the use of standardized clinical information technology systems designed to—

(A) improve the coordination and quality of care furnished to medicare beneficiaries with chronic conditions; and

(B) increase administrative efficiencies of such entities.

(2) CARE COORDINATORS AS ELIGIBLE ENTITIES.—In this section, an eligible entity is a care coordinator who furnishes care coordination services to medicare beneficiaries under section 1897 of the Social Security Act.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a care coordinator shall—

(1) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the clinical informa-

tion technology system that the care coordinator intends to implement using amounts received under the grant;

(2) provide assurances that are satisfactory to the Secretary that such system, for which amounts are to be expended under the grant, conforms to the standards established by the Secretary under part C of title XI of the Social Security Act, and such other standards as the Secretary may specify; and

(3) furnish the Secretary with such information as the Secretary may require to—

(A) evaluate the project for which the grant is made; and

(B) ensure that funding provided under the grant is expended for the purposes for which it is made.

(c) MATCHING REQUIREMENT.—The Secretary may not make a grant to a care coordinator under subsection (a) unless that care coordinator agrees that, with respect to the costs to be incurred by the care coordinator in carrying out the activities for which the grant is being awarded, the care coordinator will make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount

equal to $1 for each $1 of Federal funds provided under the grant.

(d) REPORTS TO CONGRESS.—

(1) INITIAL REPORT.—Not later than 18 months after the first grant has been made under this section, the Secretary shall submit an initial report to Congress containing the information referred to in paragraph (3) as well as any recommendations with respect to grants under this section.

(2) FINAL REPORT.—Not later than 6 months after the last grant has been awarded (as determined by the Secretary) under this section, the Secretary shall submit a final report to Congress containing the information referred to in paragraph (2) as well as any recommendations with respect to grants under this section.

(3) CONTENTS OF REPORT.—The reports under this subsection shall include the following:

(A) A description of the number and nature of grants made under this section.

(B) An evaluation of—

(i) improvements in the coordination and quality of care furnished to beneficiaries with chronic conditions; and

(ii) increases in administrative efficiencies of care coordinators.

(e) AUTHORIZATION OF APPROPRIATIONS.—For each of fiscal years 2005, 2006, and 2007, there are authorized to be appropriated to the Secretary $10,000,000 to carry out the program under this section.

Subtitle C—Additional Provisions

SEC. 121. REVIEW OF COVERAGE STANDARDS.

(a) REVIEW.—With respect to determinations under section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)) (relating to whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury for purposes of payment under title XVIII of such Act), the Secretary of Health and Human Services shall conduct a review of—

(1) regulations, policies, procedures, and instructions of the Centers for Medicare & Medicaid Services for making those determinations; and

(2) policies, procedures, local medical review policies, manual instructions, interpretative rules, statements of policy, and guidelines of general applicability of fiscal intermediaries (under section 1816 of the Social Security Act (42 U.S.C. 1395h)) and carriers under section 1842 of such Act (42 U.S.C. 1395u) for making those determinations.

(b) MODIFICATION.—Insofar as the Secretary determines that the Centers for Medicare & Medicaid Services, a fiscal intermediary, or a carrier has misapplied such standard by requiring that the item or service improve the condition of the patient with respect to such illness or injury, the Secretary shall take such corrective measures as are appropriate to ensure the Centers, intermediary, or carrier (as the case may be) applies the proper standard for making such determinations.

(c) REPORT.—On the date that is 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report that contains—

(1) a detailed statement of the findings and conclusions of the review conducted under subsection (a);

(2) a detailed statement of the modifications made under subsection (b); and

(3) recommendations to avoid misapplication of the standard in the future.

TITLE II—INSTITUTE OF MEDICINE STUDY ON EFFECTIVE CHRONIC CONDITION CARE

SEC. 201. INSTITUTE OF MEDICINE MEDICARE CHRONIC CONDITION CARE IMPROVEMENT STUDY AND REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall contract with the Institute of Medicine of the National Academy of Sciences to—

(A) conduct a comprehensive study of the medicare program to identify—

(i) factors that facilitate provision of effective care (including, where appropriate, hospice care) for medicare beneficiaries with chronic conditions; and

(ii) factors that impede provision of such care for such beneficiaries,

including the issues studied under paragraph (2); and

(B) submit the report described in subsection (b).

(2) ISSUES STUDIED.—The study required under paragraph (1) shall—

(A) identify inconsistent clinical, financial, or administrative requirements across provider and supplier settings or professional services with respect to medicare beneficiaries;

(B) identify requirements under the program imposed by law or regulation that—

(i) promote costshifting across providers and suppliers;

(ii) impede provision of effective, seamless transitions across health care settings, such as between hospitals, skilled nursing facilities, home health services, hospice care, and care in the home;

(iii) impose unnecessary burdens on such beneficiaries and their family caregivers;

(iv) impede the establishment of administrative information systems to track health status, utilization, cost, and quality data across providers and suppliers and provider settings;

(v) impede the establishment of clinical information systems that support continuity of care across settings and over time; or

(vi) impede the alignment of financial incentives among the medicare program, the medicaid program, and group health plans and providers and suppliers that furnish services to the same beneficiary.

(b) REPORT.—On the date that is 18 months after the date of enactment of this Act, the Institute of Medicine of the National Academy of Sciences shall submit to Congress and the Secretary of Health and Human Services a report that contains—

(1) a detailed statement of the findings and conclusions of the study conducted under subsection (a); and

(2) recommendations to improve provision of effective care for medicare beneficiaries with chronic conditions.

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